

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 5 8 9 0  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John Francis Betley		2a. DATE OF DEATH MONTH DAY YEAR June 29, 1982	
3 SEX Male		2b. HOUR 4:23 <sup>A</sup> <sub>M</sub>	
4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 27, 1915	
6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer/Machinist		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Delaware		13b. COUNTY New Castle	
13c. CITY OR TOWN Wilmington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 716 S. DuPont Street		14. FATHER'S NAME FIRST MIDDLE LAST Francis Betley	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Salomea Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no	
16b. SOCIAL SECURITY NO. 221 01 0011		17. INFORMANT ADDRESS Yasik Funeral Home Wilm. Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) - Probable Acute Massive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) Cardiogenic Shock.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 29, 1982, to June 29, 1982, that (I) (we) lost saw the deceased alive on June 29, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Patrick A. Molony, M.D.		22c. DATE SIGNED 6/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony, M.D.		22e. ADDRESS Chestertown, Maryland 21620	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/2/82	
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		23d. LOCATION Wilmington, Del. STATE	
24. FUNERAL DIRECTOR NAME J. Wells Wells		25a. DATE REC'D. BY REGISTRAR JUL 1 1982	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

United States

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-Farming House, 11. 11. 11.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 5 8 9 1	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>George Rothburn Bramble</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-4-82</b>			2b. HOUR <b>9:30pm</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-22-1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent &amp; Queen Anne's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Millington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Rt. 1 Box 254</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Horace Greely Bramble</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Rebecca Haddaway</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-01-9673</b>		17. INFORMANT ADDRESS <b>Hospital Records Chestertown, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIGITALIS TOXICITY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>POSSIBLE MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>CHRONIC BRONCHITIS</b>											
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>6/4</b> 19 <b>82</b> , to <b>6/4</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If two (did) (did not) view the body after death.											
22b. SIGNATURE <b>Virginia U. Collier MD</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/7/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIRGINIA U. COLLIER MD.</b>			22e. ADDRESS <b>P.O. Box 599 CHESTERTOWN MD 21620</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-8-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MILLINGTON Cem</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>MILLINGTON KENT MD</b>			
24. FUNERAL DIRECTOR NAME <b>Edmond Fellows &amp; Son Millington</b>						25. DATE REC'D. BY REGISTRAR <b>JUN 10 1982</b>		26. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret Charlesanna Brown			2a. DATE OF DEATH MONTH DAY YEAR June 21, 1982		2b. HOUR A 5:18 M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR October 3, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Kent	13c. CITY OR TOWN Millington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. DUCKERY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIOLETA THOMAS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-14-7226	17. INFORMANT ADDRESS 21620 Hospital Records-Chestertown, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) NATURAL CAUSES PROBABLY MINUTES DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS OR RUPTURED DUE TO, OR AS A CONSEQUENCE OF (c) ANEURYSM					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 21, 1982, to June 21, 1982, that (I) (we) lost saw the deceased alive on June 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Harry P. Ross, M.D.				22c. DATE SIGNED 6-23-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry P. Ross, M.D.				22e. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-26-82	23c. NAME OF CEMETERY OR CREMATORY Chesterville Cem		23d. LOCATION CITY OR TOWN CHESTERVILLE
24. FUNERAL DIRECTOR NAME Edw. Fellows + Son		ADDRESS MILLINGTON MD 21651		25. DATE REC'D. BY REGISTRAR JUN 1 1982	





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DHMH-16 30M 2/80  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 5 8 9 3	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>William Clarence Crew Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6 / 22 / 82</b>		2b. HOUR <b>1:34 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 / 7 / 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Service</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Betterton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Box 112</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Clarence Crew Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Illie E Taylor</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>Unknown</b>		16b. SOCIAL SECURITY NO. <b>WW-2</b>		17. INFORMANT <b>218-10-8683</b>		ADDRESS <b>Hospital Records, Chestertown, MD 21620</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute massive myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>- Cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 (PART 1 OR PART 2))			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 8,</b> 19 <b>82</b> , to <b>June 22</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>June 22,</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Patrick A. Molony, M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/22/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS <b>Chestertown, Maryland 21620</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>6/23/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington, Del</b>			
24. FUNERAL DIRECTOR NAME <b>William Wells</b>						ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Theresa G. [Signature]</b>	

MEDICAL CERTIFICATION

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BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 2 1 5 8 9 4 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Henry Butler Crudden					June, 28, 1982				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White		April 19, 1912		70		745	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTH DAY YEAR	
Pennsylvania		U.S.A.				Kent County		June, 28, 1982	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
Chestertown		Kent and Queen Anne's Hospital		Manager		Gas		Rte. 4 Box 327	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Queen Anne's		Chestertown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rte. 4 Box 327	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Harry Conley Crudden					Elsie NMN Irving				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
No					-		1620-09-7473		
					Hospital Records-Chestertown, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
4960 IMMEDIATE CAUSE (a) <u>Pneumonia - (not specified)</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstruction Pulmonary Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disaster</u>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
3 weeks									
3+ years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)									
21f. LOCATION									
STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from June 8, 1982, to June 28, 1982, that (I) (we) last saw the deceased alive on June 28, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
Gottfried C. Baumann, M.D.									
22c. DATE SIGNED									
6/28/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
Gottfried C. Baumann, M.D.									
22e. ADDRESS									
Chestertown Maryland 21620									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
Cremation									
23b. DATE									
June 29, 1982									
23c. NAME OF CEMETERY OR CREMATORY									
Silverbrook									
23d. LOCATION									
Wilmington, Del.									
24. FUNERAL DIRECTOR									
J. Willis Wells									
25a. DATE REC'D. BY REGISTRAR									
JUL 2 1982									
25b. REGISTRAR'S SIGNATURE									
James Santhorn									

MEDICAL CERTIFICATION

NOTICE



General and ... June 22, 1902 ...

General and ... June 22, 1902 ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 5 8 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE W. GRUSSING</b>				2a. DATE OF DEATH <b>June 28, 1982</b>		2b. HOUR <b>11:25 AM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>2/21/1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>	
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>at Home RFD Flatland Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>State Highway Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. STREET ADDRESS <b>RFD Flatland Road</b>	
14. FATHER'S NAME <b>George F. Grussing</b>				15. MOTHER'S MAIDEN NAME <b>Ada E. Davis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>213 22 7931</b>		17. INFORMANT ADDRESS <b>Chestertown, Md. Minnie Grussing Flatland Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Severe COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/26/82</b> to <b>6/28/82</b> , that (I) (we) lost saw the deceased alive on <b>6/26/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Patrick A. Molony</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Patrick A. Molony, M.D.</b>				22e. ADDRESS <b>Chestertown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>William Wells</b>				ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1982</b>	
				25b. REGISTRAR SIGNATURE <b>James J. Nathan</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 1 5 8 9 6		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Elsie		May		Gundlach				June 25 1982		7:25 <sup>P</sup> <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		10 7 1912		69		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Pennsylvania		U. S. A.				Kent County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		Kent and Queen Anne's Hospital		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Delaware		Kent		Clayton				Rt 1, Box 1290			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Leroy NMN		Petitt		Nellie Emmajean		Hunt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		218-34-8467		Hospital Records-Chestertown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adeno Carcinoma-Primary site Unknown</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1982</u> , to <u>June 25, 1982</u> , that (I) (we) lost <u>saw the deceased alive on June 25, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Robert W. Farr, M. D.				Chestertown, Maryland		21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/28/82		Sudlersville Cem.		Sudlersville, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
H. Wells		Chestertown, Md.		JUN 30 1982		James S. Nathan					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		7. REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Joseph Pennell Johnson		6 8 82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	White	9 8 12	69
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Pennsylvania	U.S.A.		Kent County MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Chestertown	the Kent and Queen Anne's Hospital		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE		13b. CITY OR TOWN	13c. STREET ADDRESS
Maryland	Kent	Chestertown	Route 1, Box 344 Deep Landing Rd
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
William Percival Johnson	Helen Goode Connors		Yes
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
177-10-4762		Hospital Records--Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure and cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary fibrosis</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>one hr</u> <u>year</u> <u>year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>AUGUST 19 74</u> , to <u>8 JUNE 19 82</u> , that (I) <u>we</u> last saw the deceased alive on <u>8 June 19 82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<u>Harry P. Ross</u>	<u>M.D.</u>	<u>9 June 1982</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
Harry P. Ross, M.D.	Chestertown, Maryland 21620		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	6/12/82	St. Paul's Cemetery	near Chestertown, Md.
24. FUNERAL DIRECTOR NAME	25. DATE REC'D. BY REGISTRAR	26. SIGNATURE OF REGISTRAR	
<u>J. Willis Wells</u>	<u>JUN 14 1982</u>	<u>Francis J. Wells</u>	

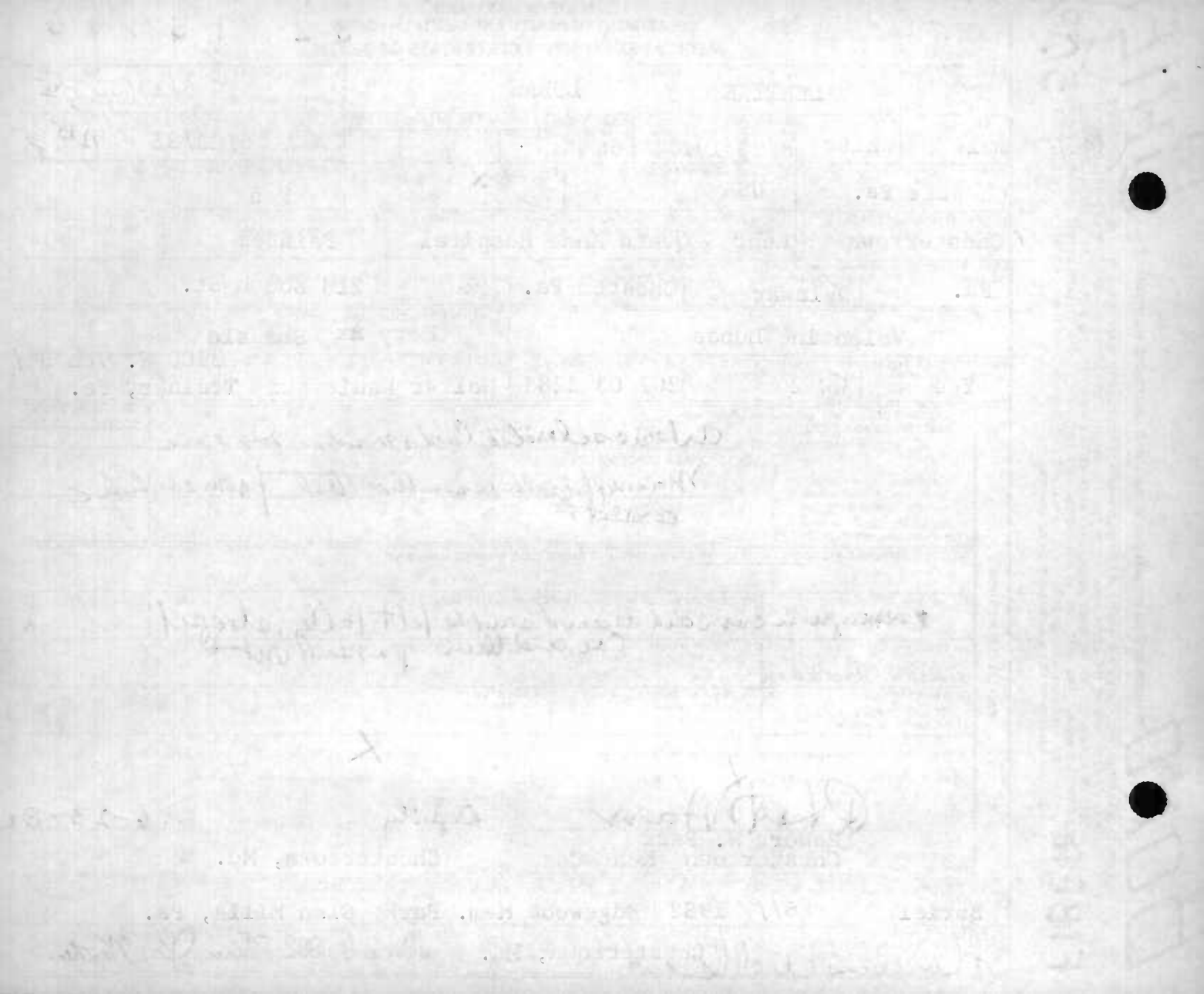


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 1 5 8 9 9									
1. DECEASED NAME (TYPE OR PRINT) <b>Evelyn Mae Moffett</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 16 82</b>			7b. HOUR P M <b>8:10 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 23 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife &amp; Campbell Soup</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Victor Lewis Crumkilton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Mercer</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-26-8394</b>		17. INFORMANT ADDRESS <b>Hospital Records - Chestertown, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive Pulm Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>May 21 1982</b> to <b>June 16 1982</b> , that (I) (we) lost saw the deceased alive on <b>June 16 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE <b>Wayne D. Benjamin</b>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6-18-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wayne D. Benjamin, M. D.</b>			22e. ADDRESS <b>Chestertown, Maryland 21620</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rock Hall, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Willis Wells</b>			ADDRESS <b>Chestertown, Md.</b>			25a. DATE REC'D BY REGISTRAR <b>JUN 21 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James Jan Nathan</b>	

BP

DHMH - 16 25M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked ar, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE													
<div>1. FOR STATE REGISTRAR</div> <div>8 2 1 5 9 0 0</div> <div>CERTIFICATE OF DEATH</div> <div>REG. NO.</div>													
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Frances Irene Mulford				June		25		1982				3:25 <sup>P</sup> <sub>M</sub>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		1 MONTH 18 24		61		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				Kent County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown				Kent and Queen Anne's Hospital				Housewife					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Kent		Chestertown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		216 Kent Circle			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST						FIRST MIDDLE LAST							
Alpheus Aldred Andrews						Mary Mae Magness							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
No				220-03-8182		Hospital Records-Chestertown, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1890 Metastatic Hypernephroma, Lt Kidney												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF												6 years.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure Diabetes													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1982, to June 25, 1982, that (I) (we) last saw the deceased alive on June 25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (not) view the body after death, so state.)													
22b. SIGNATURE								DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Charles P. Adamo M.D.												6/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS					
Charles P. Adamo, M. D.								Chestertown, Maryland 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				6/29/82		Chester Cemetery				Chestertown, Md.			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Name: J. Willis Wells								ADDRESS: Chestertown, Md.		JUN 30 1982 Frances Jean Kathan			

BP

U. S. A. 1 2 3 4 5 6 7 8 9 10 11 12

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 1 5 9 0 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>James Allison Munson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 8 82</b>			2b. HOUR <b>3:11</b> A M				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 15 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Chestertown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kent and Queen Anne's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Chestertown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>367 Calvert Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Thomas Munson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Yorker Graves</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>212-16-1105</b>		17. INFORMANT ADDRESS <b>Hospital Records - Chestertown, Maryland</b> 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hr.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 8, 19 82</b> , to <b>June 8, 19 82</b> , that (I) (we) lost saw the deceased alive on <b>June 8, 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>B. Berman MD</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/8/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Brian Berman, M. D.</b>					22e. ADDRESS <b>Chestertown, Maryland 21620</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jane's Cemetery</b>		23d. LOCATION CITY OR TOWN STATE <b>Chestertown, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James Perkins - Rock Hall, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James Perkins</i>			

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN: PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 15902	
1. DECEASED NAME (TYPE OR PRINT) <b>Rebecca Jane Schultz</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>6-13-82</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 30-1902</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>79 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>6-14-82</b>		2b. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Kent</b>					
10. CITY OR TOWN OF DEATH <b>Rock Hall</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>at her home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired food co.</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Rock Hall</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>Coelman Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Clarence Scott</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Etta Anderson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>184-09-8475-A</b>		17. INFORMANT <b>Emma Kuliga</b>		ADDRESS <b>422 Priviet Rd. Horsham Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Robert W. Farr</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER				DATE SIGNED <b>6-14-82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>ROBERT W. FARR</b>		ADDRESS <b>Chesterton, Kent Co - Md</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6-16-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Laurell Hill</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bala Cynrod Pa.</b>			
24. FUNERAL DIRECTOR NAMED <b>Helfenbein-Hubbard</b>		ADDRESS <b>Box 606 Chester Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 21 1982</b>		REG. NO. <b>15902</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 1 5 9 0 3	
1 - FOR STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Paul NMN Sipala						2a DATE OF DEATH MONTH DAY YEAR 6/ 11/ 82		2b HOUR 2:45 A			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 8 / 31 / 04		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sicily, Italy		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD					
10 CITY OR TOWN OF DEATH Chestertown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b KIND OF BUSINESS OR INDUSTRY Shoe Store			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE COUNTY Maryland Kent				13c CITY OR TOWN Chestertown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 227 High Street			
14 FATHER'S NAME FIRST MIDDLE LAST Michelle NMN Sipala				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marianna NMN Mangiafico							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17 INFORMANT ADDRESS Hospital Records - Chestertown, MD 21620					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCUD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ADULT ONSET DIABETES MELLITUS</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 2500 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS 3 YEARS 3											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>May 23,</u> 19 <u>82</u> , to <u>June 11</u> , 19 <u>82</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>June 11,</u> 19 <u>82</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b SIGNATURE <u>Harry P. Ross</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>6-11-82</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Harry P. Ross, M. D.				22e ADDRESS Chestertown, Maryland 21620							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) entombment		23b DATE 6/15/82		23c NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Chestertown Md.					
24 FUNERAL DIRECTOR NAME <u>Willis Wells</u>				ADDRESS Chestertown, Md.		25 DATE REC'D. BY REGISTRAR JUN 18 1982					
						26 REGISTRAR'S SIGNATURE <u>James San Martin</u>					

BP \_\_\_\_\_

REAR FLOOR

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REAR

REAR CHAIR DIMENSIONAL REAR

X

X

REAR FLOOR

REAR

FOR STATE  
HEALTH DEPT.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last WALTER STANLEY SOHA			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year June 23 1982		2b. HOUR 5:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 2, 1915	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year June 23, 1982
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Kent		Md.			
10. CITY OR TOWN OF DEATH Kennedyville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kentmore Park		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Shipping	
12b. KIND OF BUSINESS OR INDUSTRY Tool Co.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Kennedyville	
13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER Kentmore Park			
14. FATHER'S NAME First Middle Last Anthony Soha			15. MOTHER'S MAIDEN NAME First Middle Last Eva Pszegon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 162-07-0307		17. INFORMANT ADDRESS Mrs. Grace Soha, as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Robert W. Farr, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED June 25, 1982	
ADDRESS (Street, city, town, or county) Chestertown, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/26/82		23c. NAME OF CEMETERY OR CREMATORY Old Bohemia Cemetery	
23d. LOCATION (City or Town) (County) (State) Warwick Cecil					
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md.		ADDRESS 21651		25. REC'D BY REGISTRAR DATE JUN 1 1982	

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2303. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH



SIGNATURE OF EXAMINER

DATE

STATE OF TEXAS  
MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 7/77  
(VR A 15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 2 1 5 9 0 5  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P		
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			June 12, 1982			11:37 AM		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR		
Male			White			July 6, 1899		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Maryland			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Chestertown			Kent and Queen Anne's Hospital			Carpenter		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE			13b. COUNTY		
---			Maryland			Kent		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Galena			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			General Delivery		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		
James Leonard Turner			Margaret NMN Miller			No		
16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			21620		
221-03-0992			Hospital Records - Chestertown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Acute Myocardial Infarction								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary edema								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease - History of Atherosclerosis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (s)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from June 12, 19 82, to June 12, 19 82, that (I) (we) last saw the deceased alive on June 12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE						DEGREE		22c. DATE SIGNED
Patrick A. Molony, MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		6/15/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS		
Chestertown, Maryland						21620		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			6-16-82			Galena Cemetery		
23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
Galena			Kent			MD		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		
Edw. Fellows and Son Millington, MD 21655						JUN 24 1982		

